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The Structured Clinical Interview for *DSM-III-R* (SCID)

I: History, Rationale, and Description

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• The history, rationale, and development of the Structured Clinical Interview for *DSM-III-R* (SCID) is described. The SCID is a semistructured interview for making the major Axis I *DSM-III-R* diagnoses. It is administered by a clinician and includes an introductory overview followed by nine modules, seven of which represent the major axis I diagnostic classes. Because of its modular construction, it can be adapted for use in studies in which particular diagnoses are not of interest. Using a decision tree approach, the SCID guides the clinician in testing diagnostic hypotheses as the interview is conducted. The output of the SCID is a record of the presence or absence of each of the disorders being considered, for current episode (past month) and for lifetime occurrence.

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Structured diagnostic interviews for use by trained clinicians have played an important role in psychiatric research for several decades.[1-3] This article describes the history, rationale, and development of the Structured Clinical Interview for *DSM-III-R* (SCID),[4] an instrument in this tradition that assesses 33 of the more frequently diagnosed Axis I *DSM-III-R* disorders in adults. In an accompanying article, we describe the results of a multisite reliability field trial of the SCID. The SCID-II, a companion instrument, designed to evaluate *DSM-III-R* Personality Disorders, will be described in a separate report.

See also p 630.

HISTORY

The publication of *DSM-III* in 1980[5] limited the usefulness of the existing clinical structured diagnostic assessment instruments because they were designed to yield diagnoses according to criteria that predated the *DSM-III* criteria. The most widely used structured interview in this country, the Schedule for Affective Disorders and Schizophrenia (SADS),[3] yielded diagnoses according to the Research Diagnostic Criteria[6]; the Present State Examination,[1] widely used in international research, relied on a computer program (CATEGO)[7] that yielded behavioral syndromes intended to approximate the diagnostic categories of the ninth revision of the *International Classification of Diseases, Ninth Revision* (*ICD-9*).[8] The Renard Diagnostic Interview[2] yielded diagnoses according to the criteria of Feighner et al.[9]

The major contribution of *DSM-III* was its inclusion of specified diagnostic criteria for virtually all of the mental disorders. This made possible, at about the same time as the publication of *DSM-III*, the development of the National Institute of Mental Health (NIMH) Diagnostic Interview Schedule (DIS).[10] The DIS was designed for use by lay interviewers with 1 week of intensive training. Although originally developed for use in the Epidemiologic Catchment Area Study[11] in which the cost of employing clinically trained interviewers would have been prohibitive, it has been used by investigators in a large number of nonepidemiologic studies.

In the presidential address at the 1983 annual meeting of the American Psychopathological Association, titled "Are Clinicians Still Necessary?" one of us (R.L.S.) discussed the potential limitations of the DIS in clinical research.[12] Without questioning the advances embodied in the DIS, it was argued that the most valid diagnostic assessment still required the skills of a clinician with experience in evaluating a range of psychopathology. Unlike a lay interviewer administering a completely structured interview, such as the DIS, an experienced clinician can tailor an interview by phrasing questions to fit the subject's understanding, asking additional questions that clarify differential diagnosis, challenging inconsistencies in the subject's account, and judging whether the subject's description of an experience conforms to the intent of a diagnostic criterion. This is particularly true in the diagnostic evaluation of subjects with psychotic symptoms who have little insight and present with a complicated story from which the interviewer must discern the symptom profile. For these reasons, two of us (R.L.S. and J.B.W.W.) started work on a clinical assessment procedure that would not only be linked to *DSM-III* but would incorporate several features not present in previous clinical diagnostic instruments.

In 1983, the NIMH, also recognizing the need for a standard clinical diagnostic assessment procedure for making *DSM-III* diagnoses, issued a request for a proposal to de-

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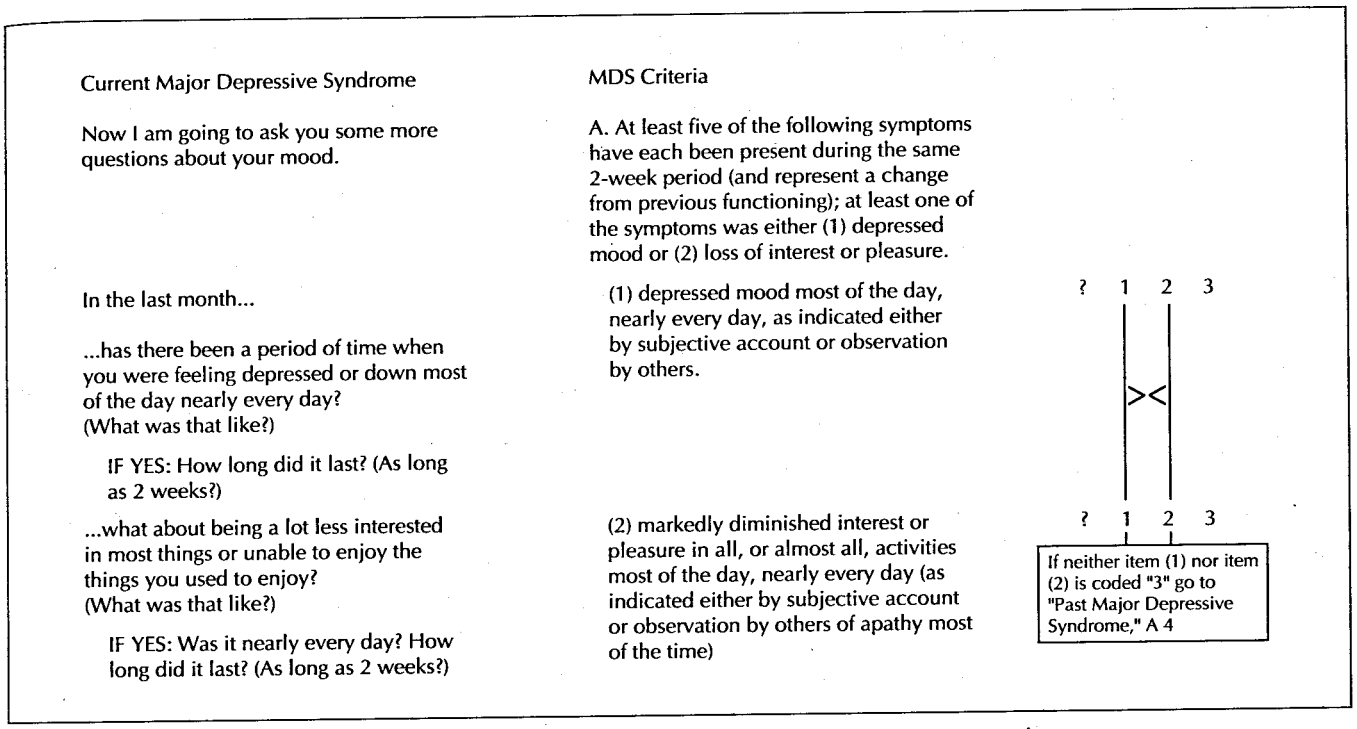

An illustration of the Structured Clinical Interview for DSM-III-R *(SCID). MDS indicates major depressive syndrome.*

velop such a procedure. Based on our pilot work with the SCID, we applied for this competitive grant and were awarded a contract to further develop the instrument.

In April 1985, we were awarded a 2-year grant to field test the SCID to determine its reliability in several different clinical and nonclinical (community) subject groups. During this field trial the diagnostic criteria for *DSM-III* were being revised for eventual publication in *DSM-III-R*[13] and were included in the versions of the SCID that were field tested. The simultaneous development of the SCID interview questions and the *DSM-III-R* criteria was helpful in revealing ambiguities and inconsistencies in the developing criteria and in suggesting more precise wording that would facilitate the clinical and research use of the criteria. Since the end of the field trial in 1987, the SCID has undergone several revisions based on both our use of the instrument and its widespread use by other research investigators and clinicians.

FEATURES

Basic Structure of Instrument

Two alternative logical strategies can be used in the construction of structured diagnostic interviews. In the first, algorithms for making decisions about which diagnoses to assign are extrinsic to the structure of the interview and are applied, by hand or by computer, when the interview is completed. That is, the rules for summarizing symptom data into diagnoses are not included in the interview schedule itself. Therefore, virtually all symptoms of diagnostic relevance are inquired about. Examples of this approach include the NIMH DIS, the SADS, and the Present State Examination. The advantages of this approach are a comprehensive symptom assessment and minimizing bias from premature closure about the presence or absence of a diagnosis under consideration. The disadvantages are that this approach leads to a lengthy interview, and the interviewer does not know when he or she needs to pay special attention to items that are of crucial diagnostic significance because of what has already been learned in the interview.

In the second approach, modeled on the clinical interview, the diagnostic algorithms are integral to the structure of the interview so that various diagnostic hypotheses are successively tested. Questions are grouped by diagnosis and by criteria. Within each diagnosis, if a required criterion is not met, the interviewer is instructed to skip the remaining questions for the other criteria for that diagnosis. Thus, items of no diagnostic significance for a particular case are passed over. With this approach the interviewer can make diagnoses as the interview progresses.

This second approach has guided the development of the SCID. As can be seen in the Figure, the three-column format of the SCID places the questions in the left-hand column, the corresponding *DSM-III-R* criteria in the middle column, and the ratings and instructions that operationalize the diagnostic algorithms in the right-hand column. The interviewer asks questions about each of the criteria (or each part of a criterion that contains two or more components) and records his or her judgment as to whether each criterion is met.

Unlike the overview (described below), which contains predominantly open-ended questions, the diagnostic modules usually begin with close-ended questions that invite a "yes" or "no" answer. These questions are followed by a request for elaboration, such as "Tell me about that," or "What was that like?" Specific follow-up questions are included to clarify responses and to obtain additional information to make the ratings. Often the interviewer will have to add his or her own questions. The rationale for allowing for clinical judgment in modifying and supplementing the SCID interview questions is that the validity of the interviewer's rating will thereby be increased, although perhaps at the expense of some degree of interrater reliability.

A fundamental principle of the SCID is that, although the interviewer is asking one or more structured questions about each diagnostic criterion, the ratings are of the *criteria*, and not necessarily the answers to the questions. If the interviewer suspects that a particular symptom is present, he or she does not allow a subject's denial of the symptom to go unchallenged. For example, if the subject appears depressed during the interview but denies a depressed mood, the interviewer would comment on the subject's appearance and probe the issue further. In rare cases, an item may be coded as present, even when the subject steadfastly denies it, eg, a subject denies that spending 2 hours a day in a handwashing ritual is "time-consuming." However, if there is reason to doubt a subject's positive response to a question, the interviewer

is obliged to ask for an elaboration or example. If the interviewer still doubts that a symptom is present, the item is rated as "not present."

The specific ratings of the diagnostic criteria are coded as either 1, 2, 3, or ?: 1 indicates that the symptom described in the criterion is clearly absent or that the criterion statement is clearly false; 2, a subthreshold condition that almost meets the threshold for the criterion (eg, a 10-day period of depressed mood, rather than the required 2 weeks); 3, that the threshold for the criterion is just met or more than met or that the criterion statement is true; and ?, that there is inadequate information to code the criterion as either 1, 2, or 3.

Using the example of the criteria for bulimia nervosa, a 1 rating for the first criterion would indicate that there was no evidence suggesting the presence of binge eating episodes and would lead the interviewer to skip to the next section. A rating of 2 would be appropriate if the subject answered "yes" to the question, but the description of a typical "binge" did not, in the interviewer's judgment, involve enough food to meet the criterion of "a large amount." A rating of 3 would be made if the description of the binges, in the interviewer's judgment, clearly met the criteria for recurrent binge eating. A ? rating would be made if the subject, for example, claimed to have had binges many years ago but could not remember any details about them. The last item that is rated for bulimia nervosa is the summary statement that if the five criteria for the disorder are all coded 3, the diagnosis is then made.

Overview of Present Illness

The SCID begins with an overview section that follows the general structure of a clinical diagnostic interview. First basic demographic information is obtained, including a short work history. This is followed by questions that elicit the chief complaint, history of present and past periods of psychiatric disturbance, treatment history, and general questions about current functioning.

Starting with nonthreatening demographic questions, such as marital status and household composition, allows the interviewer an opportunity to begin to establish rapport. Additional questions about school and work history often provide the first clues about significant psychopathology. Next the subject is encouraged to describe the chief complaint and the history of the present illness. When a subject has described an experience in his or her own words, the interviewer will have much more confidence that the acknowledged symptoms are actually present. This lays the groundwork for the more structured diagnostic modules that follow the overview.

The subject's description of the development of the illness over time provides information about the context and temporal sequence that are often necessary for interpreting the diagnostic significance of information obtained later in the interview. For example, consider a subject who describes a period of hearing his own thoughts broadcast from the television set. If the subject later acknowledges depressed mood and difficulty concentrating, the interviewer knows that it is necessary to explore the possibility that the difficulty concentrating was due to the auditory hallucinations and, therefore, is not to be counted as a symptom of a major depressive syndrome.

Questions about the development of the illness are followed by questions about past treatment. Although the *DSM-III-R* diagnostic criteria virtually never include reference to treatment received, answers to these questions often provide clues to the presence of psychopathology that the subject may deny when asked about a specific symptom later in the interview. For example, if a patient reports having been treated with lithium carbonate in the past, but then denies ever having had a period of euphoric or irritable mood, the interviewer would have a basis for further questioning the denial.

The overview concludes with general questions about current functioning, including mood, physical health, use of medications and psychoactive substances, and social functioning. These questions refocus the subject on his or her current condition and provide a natural transition to the first diagnostic module, Mood Disorders, which begins with an inquiry about current depressed mood. In addition, these questions provide information necessary for the evaluation of axes III (physical conditions or disorders) and V (global assessment of functioning scale). By the time the overview is completed, the interviewer should have obtained enough information to make a tentative differential diagnosis before systematically inquiring about specific symptoms in the diagnostic modules that follow.

Modular Design and Diagnostic Coverage

Most research investigators are interested in particular diagnostic classes and do not need to assess diagnoses that are irrelevant to their research questions. For that reason, the SCID is organized into modules, each generally corresponding to a major *DSM-III-R* diagnostic class. This feature enables a researcher who is primarily interested in psychotic disorders, for example, to eliminate the Anxiety, Somatoform, and Eating Disorders modules, thereby shortening the length of time of the diagnostic assessment. The Table lists the modules that have been developed for the SCID and the disorders covered in each module. As can be seen, the SCID does not evaluate any disorders from the following *DSM-III-R* diagnostic classes: Disorders Usually First Evident in Infancy, Childhood or Adolescence, Organic Mental Disorders, Dissociative Disorders, Sexual Disorders, Sleep Disorders, Factitious Disorders, and Impulse Control Disorders. Certain less commonly diagnosed disorders within the Mood, Anxiety, and Somatoform classes are not covered in the SCID but an optional module is available for Posttraumatic Stress Disorder. Note that mood syndromes and psychotic symptoms are each evaluated in their own modules, followed by two modules in which the differential diagnosis of the corresponding diagnoses are made.

Editions

There are two standard editions of the SCID. SCID-P (Patient) is designed to be used with adult subjects who are identified as psychiatric patients. The SCID-P includes a module for making a differential diagnosis of psychotic disorders. For populations in which psychotic disorders are expected to be rare, a form of the SCID-P, SCID-P with psychotic screen only (SCID-P W/PSY SCREEN) is available. This form includes screening questions about psychotic symptoms, but excludes the lengthy and complex psychotic disorders module. The SCID-NP (Nonpatient) is for use in studies in which the subjects are not identified as psychiatric patients, eg, community surveys, family studies, and research in the primary care. The diagnostic modules of the SCID-NP are the same as those in SCID-P W/PSY SCREEN. The only difference is in the overview. In the SCID-NP there is no assumption that the subject is seeking psychiatric treatment and therefore no chief complaint. Questions such as, "Thinking back over your whole life, when were you the most upset?" are used to elicit a history of psychopathology.

Specialized editions of the SCID have been developed for use in particular studies. The SCID-UP was developed for use in a series of Upjohn-sponsored studies of panic disorder.[14] It begins with the Anxiety Module and includes greater detail about specific anxiety symptoms. The SCID-PD, an early abbreviated edition of the SCID, was designed for use in the NIMH Collaborative Study of Treatment Strategies for Schizophrenia.[15] The SCID-NP-V (Nonpatient edition for Veterans) includes an additional section in the Anxiety Disorders Module to assess Posttraumatic Stress Disorder as well as combat experience. It was used in the Veterans Affairs–funded Vietnam Veterans Readjustment Study.[16] The SCID-NP-HIV was developed for use in a longitudinal study of the relationship between social and psychiatric factors and the outcome of human immunodeficiency virus infection.[17] It includes only those disorders that are common in the general community: Mood, Anxiety, and Psychoactive Substance Use Disorders. The Structured Clinical Interview for *DSM-III-R:* Positive and Negative Syndrome Scale[18] incorporates the Positive

Diagnoses Included in SCID Modules

- Psychotic disorders
  - Schizophrenia
  - Schizophreniform disorder
  - Schizoaffective disorder
  - Delusional disorder
  - Brief reactive psychosis
  - Psychotic disorder NOS*
- Mood disorders
  - Bipolar disorder
  - Major depression
  - Dysthymia (past 2 y)
  - Other bipolar disorder (includes bipolar disorder NOS and cyclothymia)
  - Depressive disorder superimposed on chronic psychotic disorder (diagnosed as depressive disorder NOS in *DSM-III-R*)
- Substance use disorders
  - Alcohol
  - Sedatives, hypnotics, and anxiolytics
  - Cannabis
  - Stimulants
  - Opioids
  - Cocaine
  - Hallucinogens/PCP
  - Polysubstance
  - Other substances
- Anxiety disorders
  - Panic disorder
  - Agoraphobia without panic disorder
  - Social phobia
  - Simple phobia
  - Obsessive-compulsive disorder
  - Generalized anxiety disorder (past 6 mo)
- Somatoform disorders (current only)
  - Somatization disorder
  - Somatoform pain disorder
  - Undifferentiated somatoform disorder
  - Hypochondriasis
- Eating disorders
  - Anorexia nervosa
  - Bulimia nervosa
- Adjustment disorder (current episode only)
- Personality disorders (SCID-II)
  - Avoidant
  - Dependent
  - Obsessive-compulsive
  - Passive-aggressive
  - Self-defeating
  - Paranoid
  - Schizotypal
  - Schizoid
  - Histrionic
  - Narcissistic
  - Borderline
  - Antisocial
  - NOS

*NOS indicates not otherwise specified.

and Negative Syndrome Scale and yields diagnoses and symptom severity ratings.

Because of the modular nature of the SCID, it is easy to modify it for special use, and other research groups have tailored the SCID to the specific needs of their studies. Without modification, the complete SCID can usually be administered in about an hour.

Output

The basic output of a SCID evaluation is a record of the presence or absence of each of the disorders covered by the diagnostic modules. For certain diagnoses, subtypes or severity are also noted. This information is transcribed by the interviewer from the information coded in the individual modules onto a score sheet after the interview has been completed. For most diagnoses the interviewer records whether the criteria for the disorder have ever been met during the subject's lifetime, and if so, whether they also have been met during the past month. Diagnoses can also be coded as "subthreshold" if the interviewer judges that although the full criteria for the disorder are not met, many of the characteristic features are present. For certain disorders, such as Dysthymia and Generalized Anxiety Disorder, the SCID records the diagnosis only if symptoms of the disorder have been present during the past month. This was done because of the unreliability of the subject's memory for details of a past episode of a disorder defined by nonspecific symptoms. In addition, because these disorders are typically chronic, it is unlikely that they would have occurred in the past but no longer be present.

The score sheet also records the principal diagnosis, a rating on the Global Assessment of Functioning Scale (*DSM-III-R* Axis V), and an overall assessment of the quality of the information collected during the interview. For many studies, the summary information recorded on the score sheet will be the only data from the SCID evaluation that will be analyzed. Additional information is coded within the diagnostic modules for each diagnosis made. This includes the following: age at onset; if the disorder is not current, time since last had symptoms; and an estimate of the amount of time during the past 5 years that symptoms of the disorder were present.

Sources of Information

The SCID interviewer is encouraged to use all sources of information about a subject in making the ratings, such as previous hospital or clinical records, referral notes, observations of family members, and observations of other clinical staff. If there is a discrepancy between the subject's account and some other source of information, the interviewer is instructed to (gently) confront the subject with the discrepancy. In such a situation, it is the interviewer who makes the final decision as to the true state of affairs. Such ancillary information is particularly important in assessing subjects who are unreliable historians, such as subjects who are psychotic, manic, or have a history of psychoactive substance abuse or dependence.

Interviewer Qualifications and Training

Optimally, an SCID interviewer should be someone who has enough clinical experience and knowledge of psychopathology and psychiatric diagnosis to conduct a diagnostic interview without an interview guide. To the extent that this experience, knowledge, and skill are lacking, considerably more training will be necessary, including study of the *DSM-III-R Case Book*[19] and the *DSM-III-R* diagnostic logic.[20] In most studies using the SCID, the interviewers have had professional training in psychiatry, psychology, or social work.

Training of experienced clinicians begins with a careful review of the *SCID User's Guide*,[21] which explains all of the conventions of the SCID and the special instructions for using the various diagnostic modules. Also included are case vignettes with accompanying completed SCID modules. Additional videotape training materials are available, including a 6-hour didactic presentation of the principles and techniques of administering the SCID (*SCID 101*), as well as a number of videotaped interviews. Trainees should then practice administering the SCID with appropriate subjects, ideally supervised by an experienced SCID interviewer. If more than one rater is involved in a study, the raters should conduct a series of joint interviews, alternately interviewing and observing. All raters should make independent ratings and then discuss the interviewing technique and all sources of disagreements in the ratings. Ideally, to determine that the training was adequate, reliability should be assessed by conducting a series of test-retest interviews in which the interview is repeated with the same subject within a few days by a second interviewer. This procedure is particularly helpful if the interviews are audiotaped

and the interviewers listen to each other's interview and discuss sources of disagreement.

Uses of the SCID

Research.—There are three typical ways in which research investigators have used the SCID. Most often the SCID has been used to select a study population.[22,23] For example, in a study of the effectiveness of treatments for panic disorder,[24] the SCID was used to ensure that all study subjects had conditions that met the *DSM-III-R* criteria for Panic Disorder. The SCID has also been used to screen volunteers for control subjects.[25] Finally, the SCID has been used to characterize a study sample in terms of current and past psychiatric diagnoses.[26-35]

Clinical.—In clinical settings, the SCID has been administered as a routine intake procedure to ensure that all of the major axes I and II diagnoses are systematically evaluated. Using the SCID in this way helps ensure that less-experienced mental health professionals are conducting thorough diagnostic evaluations. The SCID has also been used by clinicians to confirm the major *DSM-III-R* diagnoses and document which criteria are met. In this case the clinician does his or her usual interview and then consults the appropriate module of the SCID to confirm or document a suspected *DSM-III-R* diagnosis. For example, a clinician hearing a patient describe what sounds like a past manic episode may use the manic syndrome section of the SCID mood syndromes module to systematically inquire about all of the relevant *DSM-III-R* symptoms.

Training in Diagnostic Interviewing.—Trainees in the mental health professions need to learn not only the *DSM-III-R* criteria, but also useful questions to elicit information from a patient that will be the basis for making judgments about the diagnostic criteria. Through repeated administration of the SCID, students become familiar with the *DSM-III-R* criteria and at the same time incorporate useful questions into their regular diagnostic interviews.

Other Structured Diagnostic Instruments

Prior to the publication of *DSM-III*, the most widely used diagnostic instruments were the SADS and SADS-L, which yielded Research Diagnostic Criteria diagnoses. More recent versions of instruments in the SADS family have incorporated the *DSM-III* and *DSM-III-R* diagnoses for particular diagnoses, such as anxiety disorders,[36] but no version contains all of the major *DSM-III-R* Axis I disorders. Most versions of the SADS contain numerous rating scales of individual items of psychopathology. This makes the interview much longer than a SCID interview. (Some users of the SCID, wishing such information, supplement the SCID with a standard rating scale, such as the Brief Psychiatric Rating Scale[37] or the Hamilton Depression Scale.[38]) Another feature of the SADS that makes it more difficult to use is that the full criteria for the *DSM-III-R* disorders do not appear in the instrument itself, so that the interviewer must consult them after the interview has finished.

The DIS is widely used in psychiatric research, but because of its completely structured format that does not allow for clinical judgment in the conduct of the interview or in the final diagnostic decisions, most clinicians find it uncomfortable to administer. Its primary advantage over the SCID and other clinician-administered diagnostic interviews is that it is designed for use by lay interviewers and therefore is much more economical, particularly in studies with a large number of subjects.

The Present State Examination of Wing et al,[39] recently updated to approximate *DSM-III-R* and *ICD-10* draft diagnoses, is also designed for use by clinicians, but differs from the SCID in that the diagnoses are made by a computer program rather than the interviewer. This separation of collection of the raw data from the making of the diagnosis adds the extra step of computer analysis, a step that is often impractical because it delays decision making, such as whether to include the subject in a study.

The Psychiatric Diagnostic Interview-Revised of Othmer et al[40] is also a structured diagnostic interview that is designed to provide information on 17 psychiatric syndromes, beginning with an evaluation of a possible organic brain syndrome. The Psychiatric Diagnostic Interview-Revised is similar to the SCID in its decision tree approach, but it does not provide a structured overview, nor does it include the precise wording of the *DSM-III-R* criteria.

The Anxiety Disorders Interview Schedule-Revised of DiNardo et al[41] is a structured interview designed to facilitate differential diagnosis among the *DSM-III-R* anxiety disorders and to provide detailed information about psychopathology often associated with anxiety disorders, such as Major Depression and Dysthymia. However, for other major areas of psychopathology, such as drug abuse and psychotic symptoms, only screening questions are provided.

COMMENT

The SCID has gone through many revisions in the 10 years since it was first conceived. What is remarkable is the extent to which it has been used even before the publication of this article, which formally introduces the instrument. We believe this is because the SCID has several features that make it more "clinician-friendly" than the other structured diagnostic instruments. These include the decision-tree structure of the interview and the overview section, which makes the SCID interview flow like an unstructured diagnostic interview conducted by an expert. The skip-outs and separate diagnostic modules make it easy to skip over or eliminate irrelevant diagnoses. Researchers and clinicians, wishing to make *DSM-III-R* diagnoses, appreciate having the actual criteria in front of them as they conduct the interview, and being able to make diagnoses as the interview progresses, rather than having to wait for computer analysis.

All of the features of the SCID that make it clinician-friendly are, unfortunately, also potential sources of error that can lower the reliability and validity of the diagnostic evaluations. For example, many of the SCID skip-outs may allow a clinician to *incorrectly* decide that a particular area of psychopathology need not be examined. In contrast, more structured interviews, such as the DIS, force the interviewer to ask about all areas of psychopathology. Reliability of SCID assessments may be compromised by variations in interviewing skills and style. For example, a disagreement about major depression may be because one interviewer probed more aggressively than another interviewer about a symptom necessary to clinch the diagnosis.

Structured diagnostic interviews vary in the degree to which the interview is structured and the diagnostic criteria are immediately available to the interviewer as the interview progresses. The SCID is among the less structured in that it includes an overview section and encourages follow-up questions based on clinical judgment. This lack of complete structure is balanced by the inclusion of each diagnostic criterion, taken directly from *DSM-III-R*. For research studies in which a clinical diagnostic evaluation is necessary, a SCID in the hands of a well-trained interviewer is an efficient way of systematically making *DSM-III-R* diagnoses.

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Since 1990, the SCID has been published by the American Psychiatric Press. Royalties support the diagnostic research of the Biometrics Research Department, New York State Psychiatric Institute. Researchers and clinicians working in nonprofit or publicly owned settings (including universities, nonprofit hospitals, and government institutions) may make photocopies of the SCID.

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